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Managed Risk Medical Insurance Board
HFP Advisory Panel Meeting Summary
May 8, 2012
Sacramento, California

Attendees: Jack Campana, David Rivera, Karen Lauterbach, Ellen Beck, Jan Schumann, Elizabeth Stanley-Salazar, Barbara Orozco-Valdivia

MRMIB Staff: Janette Casillas, Ernesto Sanchez, Larry Lucero, Ellen Badley, Mary Watanabe, Liliana Diaz, Theresa Gomez, A.J. Martinez, Dawn James

Introductions

Mr. Jack Campana, Healthy Families Program (HFP) Advisory Panel Chair, opened the meeting by introducing himself and asking the Panel Members and the Managed Risk Medical Insurance Board (MRMIB) staff to introduce themselves to the audience.

Review and Approval of February 14, 2012 HFP Advisory Panel Meeting Summary

The HFP Advisory Panel reviewed the February 14, 2012 meeting summary, and approved the summary as amended. (Revisions were made to page 3.)

3. State Budget Update

In lieu of Executive Director, Janette Casillas, Ernesto Sanchez, Deputy Director of Eligibility, Enrollment, & Marketing, gave a summary regarding the current state budget and its impact on the HFP.

a. Letter from the Advisory Panel members to the MRMIB Board

A copy of the HFP Advisory Panel's letter that was sent to MRMIB Chairman, Cliff Allenby, at the February 2012 MRMIB Board meeting was reviewed. Please refer to the handout.

b. Assembly and Senate hearings

Mr. Sanchez reported that the Senate Budget Committee met on March 22, 2012, and reviewed the Governor's budget proposal. The proposal included the implementation of a proposed 25% rate cut to Healthy Families providers, and a co-pay and premium increase. All of the MRMIB budget items were left open by the Senate Budget Committee. In April 2012, the Assembly Budget Committee met and rejected the Governor's proposal and came up with their own proposal. Their proposal was similar to what was proposed by the Children's advocates, the idea of moving the brightline children (children up to 133% of the federal poverty level) into Medi-Cal, but only after certain safeguards are in place. Also, the Assembly Budget Committee proposal required that a transition plan be submitted to the Policy Committees in the Assembly and the Senate. This plan covered items such as access to healthcare, handling continuity of care, and a number of different places to monitor and make sure they were ready for the transition.

c. The Future of the Healthy Families Program (HFP) - The Urban Institute Report

Mr. Sanchez explained that the report was commissioned by a number of children's advocacy groups. It recommended moving Healthy Families brightline children into Medi-Cal and required that safeguards be put in place before any transition begins. The safeguards recommended include that Medi-Cal come up with a satisfactory contractual arrangement with Kaiser, develop performance standards for the counties in processing the applications for the children, and implement the functionality to select a plan and a provider from a website similar to Healthy Famlies. These items do not currently exists with Medi-Cal, and the report recommends that they be implemented. Another issue that is raised in the report is transparency and public accountability. With MRMIB, it has public board meetings at which all of the program, policy, and operational issues are reported, also the vendor's performance standards are reported publicly. It recommended that DHCS create an advisory council for children and families that would be modeled after MRMIB, establish a transition management plan, a contact person in charge of handling consumer questions, and build on what is going to exist in 2014. Once these safeguards are in place, they need to be evaluated and monitored, give public reporting of key Medi-Cal statistics, and do an independent evaluation.

d. LAO Analysis of the Governor's Proposal

Mr. Sanchez highlighted that in the executive summary on page 3, LAO notes that the savings in the Governor's budget are much less than estimated by the Administration, that the proposal could disrupt healthcare services for HFP enrollees and have an impact on access to providers. They also recommend only the early transition of the brightline children. They also believe that this issue should be

evaluated not in a budget committee where they are talking about dollars, but instead a policy
committee that will talk more about the details of transition, impact to children, and impact on the care being delivered.

4. Legislative Update

Mr. Sanchez highlighted that on page 1 AB 43 would enact the early Medicaid expansion for the brightline children in HFP. There are also changes to legislative bill language of two bills on page 3, AB 1453 and AB 1461 that were previously presented at the February 2012 HFP Advisory Panel Meeting. On page 6 and page 7, SB 951 under essential health benefits was highlighted and also the conforming SB 1321, on page 8.

5. 2010 Cultural and Linguistic Services Survey Report

Ms. Watanabe discussed the 2010 Cultural and Linguistic Services (C&L) Survey Report that presents an overview of the services reported by the health, dental and vision plan's to meet the cultural and linguistic needs of Limited English Proficient (LEP) subscribers during the 2009-10 benefit year. The C&L Survey is just one of the tools used by the Board to monitor services provided to LEP subscribers. Other quality monitoring activities include consumer surveys, Healthcare Effectiveness Data and Information Set (HEDIS) measures, the annual grievance report and the annual out of pocket report. English speakers are more likely to reach the out of pocket maximum and to file grievances with their plan. The consumer surveys that were administered in 2011 show that 13 percent of parents needed an interpreter to speak to their child's doctor and 28 percent needed an interpreter to speak to their child's dentist. Nearly 80 percent of members or families usually or always got an interpreter when they needed one. The C&L Survey findings show that the plans are providing interpreter services and use several methods to monitor the quality of services being provided. Most plans provide interpreter services through a telephone language line, plan staff or with outside contractors. The plans use one or more methods to ensure the proficiency of translators and providers, including certification, audits, secret shopper calls and monitoring of subscriber complaints and grievances. Most of the plans provide the subscribers preferred spoken language to providers and all plans require providers to document language needs and request for interpreter services in the medical record. Several of the plans are using the results of other quality monitoring activities to identify disparities within the Healthy Families Program and have developed quality improvement projects to address these disparities.

Ms. Watanabe added that over the years, the survey results have shown that the plans appear to have the mechanisms in place to provide interpreter services, but what is still unclear is the number of families that need interpreter services, and how these services are provided and the cost. The question is to understand is whether our LEP subscribers understand how to access services and if they are experiencing barriers to receiving language assistance services and culturally-competent care. Strategies to

assess the experience of our LEP subscribers, including a survey to LEP subscribers will be looked into next year.

6. Mental Health Pilot Initiative

Ms. Badley explained that this pilot would test new strategies aimed first at improving early identification of mental health, as well as look at increasing utilization of outpatient services and improving care coordination. Also, potentially looking at inpatient services and whether children are receiving appropriate referrals after they get out of an inpatient facility, and ensure that children are not bouncing back into those same facilities. The following counties have been identified for the pilot, Yuba, Sutter, Butte, and Colusa, have about 10 -12 thousand HFP enrollees. These counties allow for an easy way to try some strategies that would be relatively manageable, but also contain enough patients to develop outcome data. Outreach efforts will be conducted this week to county mental health directors of the four counties, and will be looking more broadly at mental health, the seriously emotionally disturbed, and partnering with education, county mental health departments, and connecting with law enforcement. The goals thus far are early identification and intervention, improved continuity of care, improved care coordination between primary care providers, and mental health providers.

7. HFP Updates

a) Update on the External Quality Review Organization (EQRO) Activities

Ms. Badley reported that compliance review with the health plans will take place in 2012. To facilitate this compliance review, a meeting was organized between Health Services Advisory Group (HSAG) and representatives from the Department of Managed Health Care (DMHC) so they could fully understand state requirements for plans under the Knox-Keene Act and Title 28 regulations. HSAG and Chief Counsel, Laura Rosenthal, met to help provide context between the Knox-Keene Act and Title 28, the HFP Statute and insurance code, Title 10 regulations, and compliance for contract provisions with our contracting plans. These onsite reviews will commence in June and be completed in August 2012.

In addition, Ms. Badley added that a simplified health plan report card is currently being developed. The goal is to find a better way to present quality performance and customer satisfaction scores of the health plans that are more understandable and useful to HFP subscribers when making plan selections. MRMIB will work with the health plans on the pros and cons of using different methodologies of explaining data to consumers. The findings and recommendations will be presented to the MRMIB Board in 2013.

Ms. Badley also added that another major activity that is going to happen this year is the Quality Improvement Projects (QIPs). The health plans will be choosing their own project, and MRMIB will be working with them the next

couple months to pick one overall project that all plans will be working on together.

b) 2009/10 Out of Pocket Expenditures Report

Ms. Badley reported that Title XXI of the Social Security Act limits the sum of premiums and co-payments paid to no more than 5 percent of the annual household income for children enrolled in the Children's Health Insurance Program (CHIP). The way that the program has assured compliance with that requirement is to limit the total amount of copayment incurred per family for households to no more than $250 per benefit year. Regardless of family size, the maximum amount that a family can pay is $250. Several changes that occurred in the HFP program in 2009 significantly impacted the results of this report. For example, in November 2009, copayments and premiums increased for families in income Categories B and C; those with incomes over 150 percent of the Federal Poverty Level (FPL). The number of families that reached the $250 co-pay maximum increased almost three times from 2008-2009, and 2009-2010. In the 2008-2009 benefit year, there were 549 families that reached the copayment maximum. In the 2009-2010 benefit year, a total of 3,479 families reached the copayment maximum for services in 15 months. Also, 1,636 families reached the annual $250 copayment maximum, using 12 months of data. Out of all enrolled families, less than 1% of families incurred copayment over $250. This was two-and-one-half times more from the year prior.

c) Updated 2011-12 Dental Plan Service Area Grid

This updated 2011-12 Dental Plan Service Area Grid is effective March 1, 2012, which includes the addition of Deltacare USA. Please refer to the handout.

d) 2011 Federal Annual Report

Ms. Badley stated that the Federal Annual Report provides a summary to the Federal government about program changes, data on enrollment, and establishment of objectives and performance goals. It also contains an assessment of state plan and program operations in the following areas: outreach, crowd-out, eligibility, enrollment, renewal and retention, dental reporting, program integrity, cost sharing, and program financing. This report also contains a section for states to report challenges and accomplishments identified in the reporting period. This report highlights accomplishments such as the Healthy-e-App program, HFP retention rate, ability to negotiate agreements with all 23 health and dental plans, reporting encounter data, conducting consumer satisfaction surveys for the health and dental plans, and the Oral Health Quality Improvement Project. HEDIS and dental measures show continued performance improvement by contracted plans. Despite financial challenges, the program is continuing to see improvement.

8. Outreach Update

a. Certified Application Assistant (CAA) Training

Mr. Lucero reported that 77 CAA's were certified last month. For the 3 month average, it is 77.3 CAA's, an increase from the 54 CAA average per month. This is not an increase in activity, this is the seasonal increase that is found in the Spring with enrollment activities and CAA's certification as well.

b. Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grants and Memorandum of Understanding (MOUs)

Mr. Lucero reported that over a year ago, both MRMIB and the Department of Health Care Services (DHCS) provided letters of commitments to over 50 organizations. A memorandum of understanding (MOU) was created, including the data use agreement which was approved by both legal staff, and consultations were provided to six of the grantees to answer questions regarding the MOUs. Also, technical assistance was provided for those grantees that need assistance enrolling or getting their EEs and CAAs affiliated with their organization. The last step was to finalize the EEs for the six grantees, and a total of 48 EEs were included for next reporting period. The first application production reports are currently being processed, which provide data from August 2011, to the end of March 2012, for those six grantees.

c. School-Based Outreach

Mr. Lucero stated that one of the primary vehicles for school based outreach is a free service that HFP provides to school based entities, known as Request for Information Flyers (RFI). Organizations can contact MAXIMUS, MRMIB's administrative vendor, via the internet to create semi-customizable flyers that are copied back to back in English and Spanish. The flyers also include the URL address for the Health-e-App public access, so that families are made aware that they can apply online. Traditionally, MAXIMUS would reaching out to the schools around June, July, and August, prior to the beginning of the new school year, to see if they wanted RFI's for their back to school packages. They found that the schools were creating these packages in April, May, and June, just before the end of the school year. MAXIMUS then contacted 500 principals in these school districts, and immediately saw an increase in the RFI's. About 1,000 RFI's have been requested in the previous two months. In April, it increased to 59,000, as a result of the outreach. Last year, about 665,000 RFI's were supplied to the schools free of charge.

d. Health-e-App Public Access a Research Brief by MATHEMATICA

Mr. Lucero stated that MATHEMATICA, conducted an independent analysis and released is first reporting brief on the experiences that both applicants and CAAs had with the Health-e-app public access within the first year of its release. The information provided for these briefing studies are done through data provided by MAXIMUS that looks at the overall utilization of Health-e-app, as well as an online survey that is available to families. About 4,000 public users utilized Health-e-app each month within the first year. The contribution by Health-e-app made an increase in total applications. Mr. Lucero added that it's encouraging to see that rural counties utilize Health-e-app quite a bit because it was unexpected, but good to see. Health-e-app continues to prove the point that it is faster, has a higher application completion rate, and the number of public users is increasing. As of today, there are about 49,000 Health-e-app public access users which include CAAs. It continues to be a very successful vehicle in providing access to healthcare to uninsured families in HFP as well as Medi-Cal.

An audience member asked if any of the other HFP forms such as the Annual Eligibility Review (AER) form and the Program Review form will be available online. Mr. Lucero replied that the 3rd phase of the Health-e-App public access is in process, which includes the AER form, the Add a Person form, Program Review form, and the Continued Enrollment form. The target date to launch these forms online will be in late June, and then the Spanish versions will follow after that. The final phase is to add the AIM Program, which is scheduled before the end of this year.

e. Outreach and Social Media update

Mr. Lucero reported that MRMIB has been working with philanthropic partners and foundations to seek grant funds to perform outreach activities for the Health-e-App Public Access. MAXIMUS performed five outreach activities during the month of April in the areas of Roseville, Norwalk, Rancho Cordova, and two events in Sacramento. A large event is scheduled in Modesto on May 18-19, 2012. Additional events will be scheduled in June and August. To date, the HFP website has about 9.5 million website hits, 1,000 Facebook followers, and a couple hundred followers on the HFP Twitter page.

HFP Informational Reports

1. Enrollment and Single Point of Entry Report

Please refer to the handout for enrollment reports for the months of January, February, and March.

2. Administrative Vendor Performance Report

Mr. Sanchez was pleased to report that the vendor met all the performance and quality standards. Please refer to the handout.

3. 2011 HFP Open Enrollment (OE) Report

Mr. Sanchez reported that 1.3% of HFP subscribers changed plans, and 17.6% were required to make a plan change because their plan was no longer available. Of those HFP subscribers required to make a change during OE, slightly less than half made an active selection. The rest are transitioned into the Community Provider Plan or are alternately assigned. Mr. Sanchez stated that in the past few years, the percent of required plan transfers was much higher. This year, the percent of required plan transfers are down to about 1.5%. The vast majority of HFP subscribers are happy with their current plans. In addition, Mr. Sanchez acknowledged executive staff for their efforts, including Chief Deputy Director, Terresa Krum, and the negotiation team in the Administrative Division at MRMIB for keeping the HFP subscriber's plan choices intact.

Mr. Sanchez also added that are three vacancies on the HFP Advisory Panel. MRMIB is seeking a representative from a County Public Health Provider, Disproportionate Share Hospital Provider, and a subscriber with a child in Healthy Families. This vacancy notice can be found on the MRMIB website.

Mr. Campana thanked everyone for coming and adjourned the meeting. Mr. Campana added that the next meeting is scheduled for August 14, 2012.